DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G223	A. BUILDING _____ B. WING _____	08/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	6217 16TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from 8/4/2010 through 8/6/2010. The survey was completed utilizing the fundamental survey process. A random sampling of two clients was selected from a residential population of three males and one female with varying degrees of mental and physical disabilities. The findings of the survey were based on observations and interviews in the home and at three day programs, as well as a review of the client and administrative records, including the incident reports.	W 000	Received 8/26/10 DOH-HRLA-ICFD	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility ' s qualified mental retardation professional (QMRP) failed to ensure the coordination of services to promote the health and safety of one of four sampled clients. [Client #1] The findings include: 1. The QMRP failed to ensure all staff received training on the implementation of a client ' s behavior support plan and the use of their gait belt. [See W189] 2. The QMRP failed to ensure all staff was competent in implementing client ' s modified	W 159	1. Cross reference W189	9/10/10
			2. Cross reference W194	8/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance C. Reese — TITLE: Program Director — (X6) DATE: 8/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 food texture. [See W194] 3. The QMRP failed to ensure clients were provided the use of their adaptive equipment in the manner prescribed on their habilitation plans. [See W436] 4. The QMRP failed to ensure the residential staff provided meals in the form and texture as prescribed. [See W474] 5. [Cross Reference W194 & W474] Observations during dinner on 8/4/2010 and during snack time on 8/5/2010 revealed Client #1 was not provided his prescribed modified food texture for his meals. Review of the Physician ' s Order Sheets on 8/5/2010 at 3:59 p.m. revealed Client #1 was prescribed a " low fat, double portion, bite sized, chopped meat diet " on 5/21/2010. Review of the Nutrition assessment dated 5/1/2010 revealed she recommended that he be prescribed a " low fat, chopped, soft foods " diet. Interview with the facility ' s registered nurse (RN), qualified mental retardation professional (QMRP) and house manager (HM) on 8/6/2010 at 10:36 a.m. confirmed there was no evidence presented or on file at the time of survey to substantiate that the primary care physician was aware of the Nutritionist recommendations. The facility ' s QMRP failed to manage and coordinate services between the primary care physician and the nutritionist to ensure Client #1 received his meals in the form best to suit his needs.	W 159	3. Cross reference W436 4. Cross reference W474 5. Cross reference W194 & W474	9/10/10 8/10/10 8/10/10
W 167	483.430(b)(2) PROFESSIONAL PROGRAM	W 167		

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W 167	Continued From page 2 SERVICES The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the consistent provision of physical therapy services and interventions to ensure the health and safety of one of two sampled clients. [Client #1] The finding includes: [Cross Reference W194] Observation on 8/4/2010, 8/5/2010 and again on 8/6/2010 revealed the facility ' s staff rarely used the gait-belt to manage Client #1 as he ambulated around his environment. Staff was observed holding his hand, holding his arm, providing support under his armpits or holding him steady by holding his upper torso whenever he walked around his environment. Both one-to-one staff observed provided a different method of supporting Client #1 as he walked. Record review on 8/5/2010 at 2:51 p.m. revealed Client #1 ' s most recent Physical Therapy (PT) assessment was completed on 2/23/2010. This assessment recommended that " [Client #1] would benefit from a gait belt for ambulation, a walking protocol, and a helmet for safety secondary to unsteady gait and self-injurious	W 167	Staff will receive additional training from the facility's nursing staff on the use of the gait belt and the walking protocol for individual #1.	9/10/10

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W 167	Continued From page 3 behavior. " Further record review on the same day and time revealed, the PT failed to establish a consistent method for utilizing the gait-belt, failed to ensure the walking protocol incorporated the use of the gait-belt, and Client #1 was still without his helmet. Interview with the facility ' s House Manager (HM), Registered Nurse (RN) and the qualified mental retardation professional (QMRP) on 8/5/2010 at 5:05 p.m. confirmed the attending PT had not provided any services since his written assessment on 2/23/2010. Further interview with the facility ' s HM and RN revealed they were not sure what type of helmet Client #1 needed. Attempts to clarify the type of helmet Client #1 needed with the previous PT had been met with no success. According to interview, the PT who wrote the 2/23/2010 assessment resigned and was no longer providing services to the facility. As of the date of survey, there was no evidence that the facility had secured the services of a Physical Therapist to ensure Client #1 ' s health and safety.	W 167	The Physical Therapist will be consulted for further clarity on the type of helmet for Individual #1. In the future, QMRP's will review recommendation for specific instructions when adaptive equipment is required.	9/10/10
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff received training on the implementation of a client ' s behavior support plan and the use of their gait belt for one of two sampled clients. [Client #1]	W 189		

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W 189	Continued From page 4 The finding includes: Observation on 8/4/2010, 8/5/2010, and again on 8/6/2010, revealed the facility ' s staff rarely used the gait-belt as they managed Client #1 ' s balance as he ambulated around his environment. Staff was observed holding his hand, holding his arm, providing support under his armpits or holding him by his upper torso as he walked around his environment. Two of Client #1 ' s one-to-one staff was observed during the survey. Both staff implemented different methods of supporting Client #1 as he walked. In addition, one his one-to-one staff was observed holding Client #1 ' s arms and preventing him from knocking over the food and utensils that was on the table during the evening of 8/4/2010 at approximately 5:15 p.m. Record review on 8/5/2010, at 2:51 p.m., revealed Client #1 ' s most recent Physical Therapy (PT) assessment was completed on 2/23/2010. This assessment recommended that Client #1 be provided a gait belt for ambulation, a walking protocol, and a helmet for safety. Further record review on 8/5/2010, at 2:30 p.m., revealed Client #1 ' s Behavior Support Plan (BSP) dated 4/25/2010 outlined the following: " Non-Violent Physical Crisis Intervention: this should only be used as a last resort when Client #1 is a danger to self or others. Non-violent physical crisis intervention involves the use of safe, non-harmful control and restraint position to safely control [Client #1] until he can regain control of his behavior. "This manual procedure/restraint should only be used by staff that have been properly trained and certified in	W 189	Staff who are assigned to work with Individual #1 will receive training on his BSP, walking protocol and the MANDT certification.	9/10/10

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W 189	Continued From page 5 nonviolent crisis intervention procedures developed by organizations such as MANDT. " Interview with the house manager (HM) and qualified mental retardation professional (QMRP) on 8/5/2010, at 5:18 p.m., revealed three out of the five staff assigned to Client #1 as a one-to-one staff did not receive training on Client #1 ' s behavior support plan or received training on the use of the gait belt. Additional interview and record review with the HM and the QMRP on the same day and time confirmed all staff assigned to Client #1 should have received training on both his behavior support plan and the use of his gait belt.	W 189		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff was competent in implementing client ' s modified food texture for one of the three sampled clients. [Client #1] The finding includes: [Cross Reference W474] Client #1 was not provided a " bite size " textured meal on the evening of 8/4/2010. The turkey meat he was provided was pulled from the bone in long strips and served accordingly. Client #1 was also observed being served crunchy	W 194	Staff will receive additonal training on Individual #1 modified food texture as indicated in his prescribed diet by the facility's nutritionist. QMRP and Residential Manager will monitor at mealtime daily to ensure that all staff are in compliance.	8/10/10

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W 194	Continued From page 6 cheese doodles for snack on the afternoon of 8/5/2010 despite his recommendation for a chopped soft diet. The facility ' s qualified mental retardation professional (QMRP) and the house manager (HM) later confirmed that the meat and the cheese doodles were served in error. The QMRP indicated she would address the oversight immediately.	W 194		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility ' s nursing staff failed to coordinate timely services to ensure a client could receive timely medical care and follow-up for one of two sampled clients. [Client #1] The finding includes: Record review on 8/5/2010 at 3:00 p.m. revealed Client #1 ' s 1/4/2010 Audiology appointment identified he had a " cerumen impaction and cauliflower ear malformation left [ear]. The treatment could not be completed due to his behavior. A second Audiology assessment was attempted on 4/6/2010 and again he was not able to complete the appointment. The 4/6/2010 assessment listed the following recommendations: 1. Return to ENT for cerumen removal (attempts in past have been unsuccessful due to patient resistance). 2. Return when ears are clear for testing. 3. Sedation is requested if medically and legally	W 331	The primary care nurse will review medical records on a weekly basis to ensure appointments are scheduled on time. When sedation is requested the primary care nurse will ensure that sedation is administered prior to appointments. The Director of Nursing will review medical records on a monthly basis to ensure medical services are rendered on time.	9/13/10

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W 331	Continued From page 7 permissible as this patient is highly resistant to being tested. Non-behavioral measures can be used for testing if the patient is quiet/asleep. Further record review on 8/6/2010 at 12:30 p.m. revealed this client received sedations for a 1/5/2010 Renal Sonogram and an ENT appointment which he successfully completed on 1/4/2010. Interview with facility ' s registered nurse (RN) on 8/6/2010 at 10:57 a.m. confirmed, Client #1 was not sedated for his audiology appointments and because of that, he was not able to complete his appointment.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure timely dental care and treatment for one of two sampled clients. [Client #3] The finding includes: Observation 8/5/2010 at approximately 4:15 p.m. revealed, Client #1 ' s teeth were disjointed and discolored. Record review on 8/6/2010, at 10:30 p.m., revealed the following dental treatment history: 1. 9/16/2009 - Findings: Comprehensive exam, adult prophylaxis. Patient needs scaling. Will	W 356	The primary care nurse will follow-up with the dental office to schedule needed dental procedures. The primary care nurse will also document in the individuals record the attempts made to schedule the appointments.	9/15/10

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W 356	Continued From page 8 submit for pre-authorization. 2. 11/9/2009 - Registered nurse (RN) note 11/25/2009: Appointment cancelled, because the dental office is waiting on pre-authorization. 3. 3/9/2010 - Findings: Comprehensive exam, heavy calculus deposits. Patient needs scaling. Recommendation: will submit pre-authorization to Medicaid for approval. Will call to reschedule ... please sedate prior to next visit. Interview with RN on 8/6/2010, at 10:43 a.m., confirmed there has been a lapse in care due to authorization problems with securing timely treatment. The RN also confirmed Client #1 ' s oral health has declined due to the lapse in dental care. The RN stated he has made several attempts at securing timely services, but also concedes pre-authorization has been a consistent problem with securing timely dental treatment. The facility failed to ensure Client #1 received timely dental services to manage and maintain Client #1 ' s oral health since 9/16/2009.	W 356		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility ' s nursing staff failed to ensure all medications were administered as ordered for one of two sampled clients. [Client #2] The finding includes:	W 369		

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W 369	Continued From page 9 Observation on the evening of 8/4/2010 revealed Client #1 did not receive his prescribed dosage of 15mg of Zyprexa. Interview and record review with the facility ' s registered nurse (RN) on 8/6/2010, at 11:30 a.m., confirmed the medication was not provided. Further record review revealed the medication was not provided for a total of four (4) days (8/2/, 8/3/, 8/4/, 8/5/). Further interview with the RN on the same day and time revealed the medication arrived to the facility on 8/5/2010, but was not administered that evening. The facility ' s nursing staff failed to enforce and implement an effective system to ensure that all medications were administered as prescribed to ensure the health and safety of its clients.	W 369	The Director of Nursing met with the nursing staff and reviewed policies and procedures on medication administration and the primary care nurses's responsibilities to ensure all prescribed medications are available. The nursing staff who failed to administer the medication and failed to report on time received disciplinary action.	8/19/10
W 376	483.460(k)(8) DRUG ADMINISTRATION The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure the primary care physician was informed of missed medications to ensure the health and safety of one of two sampled clients. [Client #2] The finding includes: [Cross reference W369] Observation on the evening of 8/4/2010 revealed Client #1 did not receive his prescribed dosage of 15mg of Zyprexa. Interview and record review with the facility ' s registered nurse (RN) on	W 376		

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W 376	Continued From page 10 8/6/2010, at 11:30 a.m., confirmed the medication was not provided. Further record review and interview with the facility ' s RN on the same day and time revealed the primary care physician had yet to be notified of the missed administration of the Zyprexa since 8/2/1010 when it was first identified as not being available. The facility ' s nursing staff failed to enforce and implement an effective system to ensure that the primary care physician is informed of all medications errors to ensure the health and safety of its clients.	W 376	Cross reference W369	8/19/10
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure one of two sampled clients were provided the proper adaptive equipment for meals and for personal safety. [Client #1] The findings include: 1. Observation on 8/4/2010 at approximately 4:15 p.m. and again at approximately 5:20 p.m. revealed Client #1 was not provided a plate guard or a sip cup for his snack and dinner respectively. During his snack and dinner, food fell from his plate onto the dining room floor as he attempted	W 436	1. Individual #1 will be provided with a plate guard and sip cup as recommended by the nutritionist. QMRP and Residential Manager will monitor to ensure usage during meals and snacks. The nutritionist will review the OT recommendations and make corrections if warranted.	9/10/10

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W 436	Continued From page 11 to eat with hand-over-hand assistance. There was also heavy spillage of his beverage during both snack and dinner due to him not being provided a sip cut for him to use during those meals. Record review on 8/5/2010 at 3:59 p.m. revealed Client #1 ' s 5/1/2010 Nutritional assessment identified he utilizes a plate guard and a sip cup during meals. Interview with the facility ' s registered nurse (RN) on 8/6/2010 at 10:38 a.m. confirmed Client #1 should have been afforded the opportunity to drink from a sip cup and also should have been provided a plate guard during his meals as recommended. 2. [Cross Reference W167] Client #1 was never observed wearing a helmet during survey between the dates of 8/4/2010 and 8/6/2010. Record review on 8/6/2010 at 1:22 p.m. revealed he had a fall on 11/1/2009 and sustained minor injury. Record review on 8/5/2010 at 1:22 p.m. revealed on 4/7/2010 the facility ' s Committee for the investigation of Unusual Incidents reviewed the 11/1/2009 incident and concluded that Client #1 should be provided a helmet to ensure his health and safety. Interview with the facility ' s registered nurse (RN) and house manager (HM) on 8/6/2010 at 5:05 p.m., confirmed the helmet was still pending. In addition, the RN indicated that the Physical Therapist ' s (PT) recommendation was not clear. He was not sure what " type " of helmet was needed or was being recommended. Moreover, the PT that made the recommendation has since	W 436	Residential staff will receive training on the use of the appropriate adaptive equipment for individual #1. 2. The helmet will be ordered for Individual #1 as recommended by the Physical Therapist. The primary care nurse will review all recommendations and implement in a timely manner.	9/10/10 9/10/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	09G223	A. BUILDING _____ B. WING _____	08/06/2010

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W 436	Continued From page 12 resigned from his duties (5/2010) and is no longer available for consultation. The facility failed to ensure Client #1 received his helmet as recommended to ensure his health and safety.	W 436		
W 474	483.460(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency as prescribed. The findings include: Observation on the evening of 8/4/2010 at approximately 5:15 p.m., revealed Client #1 was served a regular textured meal of pulled turkey meat, stuffing, mashed sweet potatoes, coleslaw and a biscuit. Record review on 8/5/2010 at 3:59 p.m. revealed, Client #1 ' s physician ' s orders prescribed he receive a " low fat, double portion, bite sized, chopped meat diet. " In addition, on 8/5/2010, Client #1 was observed being served crunchy cheese doodles as part of his snack. Interview with the facility ' s qualified mental retardation professional (QMRP) on 8/6/2010 at 10:36 a.m. confirmed Client #1 did not receive his correct food texture during dinner on the evening of 8/4/2010 and for snacks on 8/5/2010. The QMRP and the facility ' s nurse indicated they would work to address that oversight and re-train staff immediately.	W 474	The QMRP and Residential Manager will monitor daily at meals and snacks to ensure that Individual #1 receives prescribed diet. All staff will receive additional training on prescribed diet for Individual #1.	8/10/10

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W 474	Continued From page 13 The facility failed to ensure Client #1 was provided a " bite sized, chopped meat " diet as prescribed.	W 474		

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from 8/4/2010 through 8/6/2010. A random sampling of two residents was selected from a residential population of three males and one female with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at three day programs, as well as a review of the resident and administrative records, including the incident reports.	I 000		
I 055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all residents received their meals in the form and consistency as prescribed for one of two residents in the sample. (Resident #4) The findings include: Observation on the evening of 8/4/2010 at approximately 5:15 p.m., revealed Resident #1 was served a regular textured meal of pulled turkey meat, stuffing, mashed sweet potatoes, coleslaw and a biscuit. Record review on 8/5/2010 at 3:59 p.m. revealed, Resident #1 ' s physician ' s orders prescribed he receive a " low fat, double portion, bite sized, chopped meat diet. " In addition, on 8/5/2010, Resident #1 was observed being served crunchy cheese doodles	I 055	The staff will receive training on prescribed diet for individual #1. QMRP and Residential Manager will monitor daily at mealtime to ensure prescribed diet.	8/10/10

Constance A. Reese - Program Director 8/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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I 055	Continued From page 1 as part of his snack. Interview with the facility ' s qualified mental retardation professional (QMRP) on 8/6/2010 at 10:36 a.m. confirmed Resident #1 did not receive his correct food texture during dinner on the evening of 8/4/2010 and for snacks on 8/5/2010. The QMRP and the facility ' s nurse indicated they would work to address that oversight and re-train staff immediately. The facility failed to ensure Resident #1 was provided a " bite sized, chopped meat " diet as prescribed.	I 055		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive and sanitary manner,for four of four residents in the facility. The findings include: During the environmental inspection on 4/21/2010, at 5:20 p.m., the following deficiencies were observed: 1. The toilet seat in the bathroom near the kitchen was extremely loose and could be moved from side to side with little effort.	I 090	1. The toilet seat in the bathroom near the kitchen was repaired.	8/24/10

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I 090	Continued From page 2 2. Heavy accumulation of dust on the A/C vents was observed both in Resident #1 and #2 ' s bedrooms. In addition, the vent in Resident #1 ' s bedroom was broken and hanging off the wall. 3. Holes were observed in the plaster along the walls in Resident #1 ' s bedroom. 4. The floors in Resident #1 ' s bedroom were extremely worn and in poor condition.	I 090	2. Dust on the A/C vents for individual #1 and #2 was removed and cleaned. 3. The holes in the wall in individual #1 bedroom will be repaired. 4. The floors in individual #1 bedroom will be repaired.	8/24/10 8/24/10 8/24/10
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person ' s (GHMRP) qualified mental retardation professional (QMRP) failed to ensure the coordination of services to promote the health and safety of one of two sampled residents. [Resident #1] The findings include: 1. The QMRP failed to ensure all staff received training on the implementation of a resident ' s behavior support plan and the use of their gait belt. [See Federal Deficiency Report Citation W189] 2. The QMRP failed to ensure all staff was competent in implementing resident ' s modified food texture. [See Federal Deficiency Report	I 180	1. Cross reference W189 2. Cross reference W194 & W474	9/10/10 8/10/10

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I 180	Continued From page 3 Citation W194] 3. The QMRP failed to ensure residents were provided the use of their adaptive equipment in the manner prescribed on their habilitation plans. [See Federal Deficiency Report Citation W436] 4. The QMRP failed to ensure the residential staff provided meals in the form and texture as prescribed. [See Federal Deficiency Report Citation W474] 5. [Cross Reference Federal Deficiency Report Citations W194 & W474] Observations during dinner on 8/4/2010 and during snack time on 8/5/2010 revealed Resident #1 was not provided his prescribed modified food texture for his meals. Review of the Physician ' s Order Sheets on 8/5/2010 at 3:59 p.m. revealed Resident #1 was prescribed a " low fat, double portion, bite sized, chopped meat diet " on 5/21/2010. Review of the Nutrition assessment dated 5/1/2010 revealed she recommended that he be prescribed a " low fat, chopped, soft foods " diet. Interview with the facility ' s registered nurse (RN), qualified mental retardation professional (QMRP) and house manager (HM) on 8/6/2010 at 10:36 a.m. confirmed there was no evidence presented or on file at the time of survey to substantiate that the primary care physician was aware of the Nutritionist recommendations. The facility ' s QMRP failed to manage and coordinate services between the primary care physician and the nutritionist to ensure Resident #1 received his meals in the form best to suit his needs.	I 180	3. Cross reference W436 4. Cross reference W474 5. Cross reference W194 & W474	9/10/10 9/10/10 9/10/10

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I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure all staff was provided a written job description as required by this section. [Staffs #12 and #13] The finding includes: Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) on 8/6/2010, at approximately 4:50 p.m., revealed two out of thirteen staff did not have a current signed job description in their personnel files.	I 202	Staff #12 and #13 will review their job description and sign.	8/10/10
I 205	3509.5 PERSONNEL POLICIES Each job description shall be updated, rewritten, and reviewed with the employee when, the duties and responsibilities of the job change. This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person's (GHMRP) failed to ensure the GHMRP ' s supervisory staff afforded each employee the opportunity to discuss their job descriptions at least annually as required by this section. [Staff #12 and #13] The finding includes:	I 205	QMRP and Residential Manager will discuss and review job description annually with staff #12 and #13.	8/10/10

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I 205	Continued From page 5 Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) on 8/6/2010 at approximately 4:52 p.m. revealed there was no written evidence that the facility ' s supervisor afforded two out of thirteen staff the opportunity to discuss and review their current job description over the past year.	I 205		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff received training on the implementation of a resident ' s behavior support plan and the use of their gait belt for one of two sampled residents. [Resident #1] The finding includes: Observation on 8/4/2010, 8/5/2010 and again on 8/6/2010 revealed the facility ' s staff rarely used the gait-belt as they managed Resident #1 ' s balance as he ambulated around his environment. Staff was observed holding his hand, holding his arm, providing support under his armpits or holding him by his upper torso as he walked around his environment. Two of Resident #1 ' s one-to-one staff was observed during the survey. Both staff implemented different methods of supporting Resident #1 as	I 229	Staff will receive additional training on Individual #1's Behavior Support Plan and the use of the gait belt. QMRP and Residential Manager will provide supervision and monitor daily.	9/10/10

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I 229	Continued From page 6 he walked. In addition, one his one-to-one staff was observed holding Resident #1 ' s arms and preventing him from knocking over the food and utensils that was on the table during the evening of 8/4/2010 at approximately 5:15 p.m. Record review on 8/5/2010 at 2:51 p.m. revealed Resident #1 ' s most recent Physical Therapy (PT) assessment was completed on 2/23/2010. This assessment recommended that Resident #1 be provided a gait belt for ambulation, a walking protocol, and a helmet for safety. Further record review on 8/5/2010 at 2:30 p.m. revealed Resident #1 ' s Behavior Support Plan (BSP) dated 4/25/2010 outlined the following: " Non-Violent Physical Crisis Intervention: this should only be used as a last resort when Resident #1 is a danger to self or others. Non-violent physical crisis intervention involves the use of safe, non-harmful control and restraint position to safely control [Resident #1] until he can regain control of his behavior. "This manual procedure/restraint should only be used by staff that have been properly trained and certified in nonviolent crisis intervention procedures developed by organizations such as MANDT. " Interview with the house manager (HM) and qualified mental retardation professional (QMRP) on 8/5/2010 at 5:18 p.m. revealed three out of the five staff assigned to Resident #1 as a one-to-one staff did not receive training on Resident #1 ' s behavior support plan or received training on the use of the gait belt. Additional interview and record review with the HM and the QMRP on the same day and time confirmed all staff assigned to	I 229		

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I 229	Continued From page 7 Resident #1 should have received training on both his behavior support plan and the use of his gait belt.	I 229		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person (GHMRP) failed to ensure all staff was competent in implementing a resident ' s mealtime feeding protocol for one of the two sampled residents. [Resident #1] The findings include: [Cross Reference Federal Deficiency Report Citation W474] Resident #1 was not provided a " bite size " textured meal on the evening of 8/4/2010. The turkey meat he was provided was pulled from the bone in long strips and served accordingly. Resident #1 was also observed being served crunchy cheese doodles for snack on the afternoon of 8/5/2010 despite his recommendation for a chopped soft diet. The facility ' s qualified mental retardation professional (QMRP) and the house manager (HM) later confirmed that the meat and the cheeee doodles were served in error. The QMRP indicated she would address the oversight immediately.	I 422	QMRP and Residential Manager will monitor at mealtime daily to ensure that Individual #1 is served his prescribed diet. Cross reference W474	8/10/10
I 430	3521.7(a) HABILITATION AND TRAINING	I 430		

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I 430	Continued From page 8 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure one of two sampled residents were provided the proper adaptive equipment for meals for one of two sampled residents. [Resident #1] The finding includes: Observation on 8/4/2010, at approximately 4:15 p.m. and again at approximately 5:20 p.m. revealed, Resident #1 was not provided a plate guard or a sip cup for his snack and dinner respectively. During his snack and dinner, food fell from his plate onto the dining room floor as he attempted to eat with hand-over-hand assistance. There was also heavy spillage of his beverage during both snack and dinner due to him not being provided a sip cup for him to use during those meals. Record review on 8/5/2010, at 3:59 p.m., revealed Resident #1 ' s 5/1/2010 Nutritional assessment identified he utilizes a plate guard and a sip cup during meals. Interview with the facility ' s registered nurse (RN) on 8/6/2010 at 10:36 a.m. confirmed Resident #1 should have been afforded the opportunity to drink from a sip cup and also should have been provided a plate guard during his meals as recommended.	I 430	Cross reference W167	9/10/10

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I 441	3521.7(k) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure one of two sampled residents were provided the proper adaptive equipment for personal safety during ambulation for one of two sampled residents. [Resident #1] The finding includes: [Cross Reference Federal Deficiency Report Citation W167] Resident #1 was never observed wearing a helmet during survey between the dates of 8/4/2010 and 8/6/2010. Record review on 8/6/2010 at 1:22 p.m. revealed he had a fall on 11/1/2009 and sustained minor injury. Record review on 8/6/2010 at 1:22 p.m. revealed on 4/7/2010 the facility ' s Committee for the investigation of Unusual Incidents reviewed the 11/1/2009 incident and concluded that Resident #1 should be provided a helmet to ensure his health and safety. Additional record review on the same day and time Interview with the facility ' s registered nurse (RN) and house manager (HM) on 8/6/2010 at 5:05 p.m., confirmed the helmet was still pending. In addition, the RN indicated that the Physical Therapist ' s (PT) recommendation was not clear.	I 441	Cross reference W167	9/10/10

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	6217 16TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 441	Continued From page 10 He was not sure what " type " of helmet was needed or was being recommended. Moreover, the PT that made the recommendation has since resigned from his duties (5/2010) and is no longer available for consultation. The facility failed to ensure Resident #1 received his helmet as recommended to ensure his health and safety.	I 441		